

**OFFICE OF STATEWIDE HEALTH PLANNING AND DEVELOPMENT
CALIFORNIA PATIENT DISCHARGE DATA REPORTING MANUAL, THIRD
EDITION**

For Discharge Data for the Years 1999 and 2000

**OTHER DIAGNOSES AND WHETHER THE CONDITIONS
WERE PRESENT AT ADMISSION**

Section 97226

(a) The patient's other diagnoses are defined as all conditions that coexist at the time of admission, that develop subsequently during the hospital stay, or that affect the treatment received and/or the length of stay. Diagnoses that relate to an earlier episode that have no bearing on the current hospital stay are to be excluded. Diagnoses shall be coded according to the ICD-9-CM. ICD-9-CM codes from the supplementary classification of external causes of injury and poisoning (E800-E999) shall not be reported as other diagnoses.

(b) Effective with discharges on or after January 1, 1996, whether the patient's other diagnoses were present at admission shall be reported as one of the following:

- (1) Yes.*
- (2) No.*
- (3) Uncertain.*

DISCUSSION

Format for reporting this data element on the Manual Abstract Reporting Form for discharges occurring on or after January 1, 1999:

<p>10. PRINCIPAL DIAGNOSIS</p> <p style="text-align: center;">CODE</p> <table border="1" style="margin: 0 auto; width: 150px; height: 30px;"><tr><td style="width: 30px; height: 30px;"></td><td style="width: 30px; height: 30px;"></td><td style="width: 30px; height: 30px;"></td><td style="width: 30px; height: 30px;"></td><td style="width: 30px; height: 30px;"></td></tr></table>						<p>10a. PRESENT AT ADMISSION</p> <table border="1" style="margin: 0 auto; width: 50px; height: 30px;"><tr><td style="width: 50px; height: 30px;"></td></tr></table> <p>Y = Yes N = No U = Uncertain</p>																			
<p>11. OTHER DIAGNOSES</p> <table border="1" style="margin: 0 auto;"><tr><td style="width: 20px; height: 30px;"></td><td style="width: 30px; height: 30px;"></td><td style="width: 30px; height: 30px;"></td><td style="width: 30px; height: 30px;"></td><td style="width: 30px; height: 30px;"></td></tr><tr><td style="width: 20px; height: 30px;"></td><td style="width: 30px; height: 30px;"></td><td style="width: 30px; height: 30px;"></td><td style="width: 30px; height: 30px;"></td><td style="width: 30px; height: 30px;"></td></tr><tr><td style="width: 20px; height: 30px;"></td><td style="width: 30px; height: 30px;"></td><td style="width: 30px; height: 30px;"></td><td style="width: 30px; height: 30px;"></td><td style="width: 30px; height: 30px;"></td></tr><tr><td style="width: 20px; height: 30px;"></td><td style="width: 30px; height: 30px;"></td><td style="width: 30px; height: 30px;"></td><td style="width: 30px; height: 30px;"></td><td style="width: 30px; height: 30px;"></td></tr></table>																					<p>11a. PRESENT AT ADMISSION</p> <table border="1" style="margin: 0 auto;"><tr><td style="width: 50px; height: 30px;"></td></tr><tr><td style="width: 50px; height: 30px;"></td></tr><tr><td style="width: 50px; height: 30px;"></td></tr><tr><td style="width: 50px; height: 30px;"></td></tr></table>				

Other Diagnoses:

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Reporting Requirement: Identical diagnosis codes must not be reported on the same inpatient discharge data record.

Number of Other Diagnoses: Up to twenty-four other diagnoses may be reported to OSHPD. Discharge data becomes increasingly useful and valuable for research when all diagnoses that indicate risk factors are reported. Please report all relevant diagnoses.

Other Coding Systems:

- Morphology Codes are not accepted by OSHPD.
- SNODO codes are not accepted by OSHPD.
- DSM-IV codes are not accepted by OSHPD.

ICD-9-CM Codes:

Conditions should be coded that affect patient care in terms of requiring:

- Clinical evaluation
- Therapeutic treatment
- Diagnostic procedures
- Extended length of hospital stay
- Increased nursing care and/or monitoring

Refer to the official guidelines for coding and reporting the other diagnoses in *Coding Clinic for ICD-9-CM*.

Codes from the Supplementary Classification of External Causes of Injury and Poisoning (E800-E999) will never be reported in the other diagnosis code fields. Such codes must only be reported in the External Causes of Injury code fields.

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Condition Present at Admission for Other Diagnoses:

Purpose:

The purpose of collecting the data element Condition Present at Admission is to differentiate between conditions present at admission and conditions that developed during an inpatient admission. The focus is to assess the timing of when the condition was present.

Reporting Requirements:

- Each principal diagnosis and all other diagnoses must have an indicator for reporting whether or not a condition is present at admission by choosing one of the following responses:
 - Yes
 - No
 - Uncertain
- The ICD-9-CM E-codes, External Causes of Injury and Poisoning, are excluded from this reporting requirement.

Parameters for Reporting:

If the physician states that a condition is present (Y) or not present (N) at admission or is uncertain (U) whether or not the condition was present at admission, the physician's statement takes precedence over the following parameters.

A condition is considered present at admission if it is identified in the history and physical examination or documented in the current inpatient medical records (e.g., emergency room, initial progress, initial nursing assessment, clinic/office notes).

When a condition is present prior to or at the time of the current inpatient admission, the indicator is reported yes (Y).

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When a condition develops during the current inpatient admission and it is not present prior to or at the time of the current inpatient admission, the indicator is reported No (N).

When it is not clearly indicated that a condition is present at the time of the current inpatient admission or developing during the current inpatient admission, the indicator is reported Uncertain (U).

Coding professionals will need to use their best judgment to determine whether or not a condition is present at the time of the current inpatient admission. If there is doubt as to whether or not the condition is present at admission, coding professionals are encouraged to ask the physician.

Indicators for Acute and Chronic Conditions:

Chronic conditions that may not have been identified prior to or at the time of the current inpatient admission would be considered to have been present at admission. The indicator for the chronic condition is reported Yes.

Example: Lung cancer discovered during admission 162.9 Y

When there are separate ICD-9-CM codes for some conditions that are described as both acute and chronic, the indicators are reported separately as follows:

If acute and chronic conditions are both present prior to or at the time of admission, these indicators are reported Yes.

Example: Acute and chronic bronchitis 466.0 Y and 491.9 Y, respectively

If an acute exacerbation of a chronic condition is identified during the current inpatient admission, the acute condition indicator is reported no and the chronic condition indicator is reported Yes.

Example: Acute and chronic bronchitis 466.0 N and 491.9 Y, respectively

When there are no separate ICD-9-CM codes for conditions that are described as both acute and chronic, the indicator is reported as follows:

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If acute and chronic conditions are both present prior to or at the time of the current inpatient admission, the indicator is reported Yes.

Example: COPD with acute exacerbation 491.21 Y.

If an acute exacerbation of a chronic condition developed during the current inpatient admission, the indicator is reported No.

Example: Diabetes mellitus with ketoacidosis 250.10 N.

Indicators for signs and symptoms, rule out or suspected conditions, comparative/contrasting conditions, symptoms followed by comparative/contrasting conditions, and abnormal findings:

If a sign or symptom is present prior to or at the time of the current inpatient admission, the indicator is reported Yes.

Example: Nausea with vomiting 787.01 Y.

If a suspected condition is present prior to or at the time of the current inpatient admission, the indicator is reported Yes.

Example: Rule out sepsis 038.9 Y.

If two or more comparative or contrasting conditions are present prior to or at the time of the current inpatient admission, the indicators are reported Yes.

Example: Diverticulitis versus appendicitis 562.11 Y and 541 Y, respectively.

If a symptom followed by comparative or contrasting conditions is present prior to or at the time of the current inpatient admission, all indicators are reported Yes.

Example: Chills, pneumonia versus. bladder infection 780.9 Y, 486 Y, and 595.9 Y, respectively

If a threatened or impending condition is present prior to or at the time of the current inpatient admission, the indicator is reported Yes.

Example: Threatened abortion 640.03 Y.
Impending myocardial infarction 411.1 Y.

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If an abnormal finding is present prior to or at the time of the current inpatient admission, the indicator is reported Yes.

Example: Hyponatremia 276.1 Y.

If the above conditions are not present at the time of the current inpatient admission, the indicator is reported No.

Example: Suspected postoperative infection 998.59 N.

If the above conditions are not clearly indicated as being present either at the time of the current inpatient admission or developing during the current inpatient admission, the indicator is reported uncertain.

Example: Possible urinary tract infection was diagnosed during the stay. Patient receiving antibiotics for cholecystitis prior to admission 599.0 U.

Indicators for Obstetrical Conditions:

If an antepartum condition is present prior to or at the time of the current inpatient admission, the indicator is reported yes.

Example: Pregnancy with fetal distress 656.33 Y.

If a chronic condition during delivery is present prior to or at the time of the current inpatient admission, the indicator is reported yes.

Example: Pregnancy with diabetes, delivered 648.01 Y.

If a postpartum condition is present prior to or at the time of the current inpatient admission, the indicator is reported Yes.

Example: Third degree perineal laceration following delivery at home
664.24 Y.

If the above conditions are not present at the time of the current inpatient admission, the indicator is reported No.

Example: Postpartum fever, delivered 670.02 N.

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If an acute condition develops during delivery and it is not present prior to or at the time of the current inpatient admission, the indicator is reported No.

Example: Third degree perineal laceration during delivery 664.21 N.
If the above conditions are not clearly indicated as being present either at the time of the current inpatient admission or developing during the current inpatient admission, the indicator is reported Uncertain.

Example: Delivery and breast abscess diagnosed during stay 675.11 U.

Indicators for V Codes:

If a V code identifies a birth or an outcome of delivery at the time of the current inpatient admission, the indicator is reported Yes.

Example: Newborn V30.00 Y.
Single liveborn infant V27.0 Y.

If a V code identifies the reason for admission at the time of the current inpatient admission, the indicator is reported Yes.

Example: Admission for chemotherapy V58.1 Y.

If a V code identifies a history or status at the time of the current inpatient admission, the indicator is reported Yes.

Example: Status colostomy V44.3 Y

If a V code identifies a problem that develops during the current inpatient admission, the indicator is reported No.

Example: Canceled surgery V64.1 N

If a V code identifies exposure to a communicable disease during the current inpatient admission, the indicator is reported No.

Example: Exposure to strep throat during current admission V01.8 N

If a V code identifies a situation and it is not clearly indicated as being present either at the time of the current inpatient admission or developing during the current inpatient admission, the indicator is reported Uncertain.

Example: Family disruption V61.0 U